**Texas Department of Insurance**
**Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

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|---|---|
| Requestor Name and Address:<br><br>CHRISTOPHER K LIVINGSTON MD<br>6410 FANNIN #927<br>HOUSTON, TX 77030 | MFDR Tracking #: M4-10-2937-01<br>DWC Claim #:<br>Injured Employee: |
| Respondent Name and Box #:<br><br>INSURANCE CO OF THE STATE OF PA<br>Box #: 19 | Date of Injury:<br>Employer Name:<br>Insurance Carrier #: |

## PART II: REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** As taken from the Table of Disputed Services, "Separate procedure performed on separate fingers left little finger. Separate procedure on separate finger left long finger."

**Amount in Dispute:** $2,626.95

## PART III: RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Dr. Livingston billed $9,660 for these dates of service, and the carrier reimbursed $1,718.39. Dr. Livingston's office calculated the MAR as $4,345.34 leaving a disputed amount of $2,626.95. The difference in the Requestor calculations of MAR and the Carrier reimbursement lies in the calculation for separate charges for each finger (left little finger and left long finger) The carrier reimbursed the full amount for CPT 26035 for one finger. Code 26035 is for decompress fingers/hand. If there are several fingers the code includes reimbursement for all the fingers, or for one hand. This is what the carrier allowed. The same logic applies to CPT 11043, debride tissue/muscle. This procedure and CPT 20103 (explore wound) should be included in CPT 26035 (decompress fingers/hand). The wound is cleaned as it is explored so this should be reimbursed as one procedure."

**Response Submitted by:** Chartis, 4100 Alpha Road, Suite 700, Dallas, Texas 75244

## PART IV: SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Calculations | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| 11/15/09 | 11043-F4-59 | 67.38 ÷ 36.0666 x $219.02 = $409.18 | $395.62 | $395.62 |
| 11/15/09 | 20103-F4-59 | N/A | $631.46 | $0.00 |
| 11/15/09 | 26035 | 67.38 ÷ 36.0666 x $769.70 = $1,437.96 (less 50%) = $718.98 | $572.79 | $146.18 |
| 11/15/09 | 11043-F2-59 | 67.38 ÷ 36.0666 x $219.02 = $409.18 (less 50%) = $204.59 | $395.62 | $204.59 |
| 11/15/09 | 20103-F2-59 | N/A | $631.46 | $0.00 |
| | | | **Total Due:** | $746.39 |

## PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 1/26/2010

   - "97 – Payment is included in the allowance for another service/procedure
   - W1 – Workers compensation state fee schedule adjustment
   - Our position remains the same…"

**Issues**

1. Are CPT codes 11043-F2 and 11043-F4 bundled into any other services rendered on the same day?
2. Are CPT codes 20103-F2 and 20103-F4 bundled into any other services rendered on the same day?
3. Did the respondent reimburse the requestor for CPT code 26035 per the Medical Fee Guidelines?
4. Is the requestor entitled to reimbursement?

**Findings**

1. This dispute was filed with Medical Fee Dispute Resolution (MFDR) on 2/26/2010.
2. The requestor performed surgery on the injured worker's third, fourth and fifth digits of the left hand. The requestor billed CPT code 11043 (Debridement, skin, subcutaneous tissue, and muscle) and appended modifiers F2 (left hand, third digit), F4 (left hand fifth digit) and 59 (distinct procedural service). The insurance carrier denied these services with reason code "97" (Payment is included in the allowance for another service/procedure). Per the NCCI edits, CPT codes 11043-F2 and 11043-F4 are not bundled into any other services rendered on the same day. Pursuant to rule §134.203(b)(1) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. The carrier's denial of "97" is not supported. Therefore, reimbursement to the requestor for CPT code 11043-F4-59 and 11043-F2-59 is recommended.

   The requestor also billed CPT code 20103 (Exploration of penetrating wound (separate procedure); extremity) and appended modifiers F2, F4 and 59. The AMA further clarifies, CPT codes "20100-20103 relate to wound(s) resulting from penetrating trauma. These codes describe surgical exploration and enlargement of the wound, extension of dissection (to determine penetration), debridement, removal of foreign body(s), ligation, or coagulation of minor subcutaneous and/or muscular blood vessel(s),of the subcutaneous tissue, muscle fascia, and/or muscle, not requiring thoracotomy or laparotomy, then those specific code(s) would supersede the use of codes 20100-20103. To report simple, intermediate, or complex repair of wound(s) that do not require enlargement of the wound, extension of dissection, etc, as stated above, use specific repair code(s) in the Integumentary System section. The insurance carrier denied these services with reason code "97". Per the NCCI edits, digit modifiers F2 and F4 are not appropriate when billing for this service. Therefore, reimbursement to the requestor for CPT code 20103-F2-59 and 20103-F4-59 is not recommended.

**3.** The requestor is seeking additional reimbursement for CPT code 26035 (Decompression fingers and/or hand, injection injury). The requestor's billing indicates that this code was billed twice with digit modifiers F2 and F4. On the explanation of benefits the respondent does not list the digit modifiers but reimbursed the requestor $1,145.59 for one of the billed codes and $572.80 for the other. The requestor listed CPT code 26035 on the DWC-60 table twice but did not append the modifiers as well and is seeking $0.00 reimbursement for one and listed it a second time with a payment amount of $572.80 and is seeking $572.79. It is unclear if the insurance carrier paid CPT code 26035-F2 or CPT code 26035-F4. Therefore, CPT code 26035 that the requestor listed on the DWC-60 table seeking an additional amount will be reviewed under rule §134.203. Per Medicare, CPT code 26035 has a multiple surgery status indicator of 2. Medicare further clarifies "Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1,2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, and by report)". The MAR amount for CPT code 26035 with the multiple surgery status indicator of 2 is $718.98. The respondent reimbursed the requestor $572.80; therefore, additional reimbursement is recommended.

**Conclusion**

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $746.39.

## PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $746.39 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

| Authorized Signature | Medical Fee Dispute Resolution Officer | August 17, 2011<br>Date |
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## PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**